

Expansion of the private health sector in east and southern Africa

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Executive summary

In 2007, a report by the International Finance Corporation (IFC), - part of the World Bank Group - entitled *The business of health in Africa: Partnering with the private sector to improve people's lives*, argued that expanding the private health sector is good for both investors and country populations. Whilst acknowledging the need for appropriate regulation, the report encouraged governments and external funders to facilitate private sector expansion through more business-friendly policies and to subsidise private sector initiatives. This review was commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) to explore the implications of expansion of the private for profit health sector for equitable health systems in East and Southern Africa. It summarises the rationale behind the IFC's recommendations. It then explores whether there are signs of increasing *for-profit private sector* activity in the region, along the lines suggested by the IFC. The report then identifies issues of concern on private for profit activity in the health sector. This is an initial scoping exercise based on a desk review of the predominantly grey literature on for-profit private sector activity in the health sectors of East and Southern Africa. Lack of available data means that the paper suffers from several data limitations. Further research is needed on the different for-profit private activities in the health systems of the region, to better understand their impact, particularly of the informal, for-profit private sector.

The IFC report argues for the expansion of the private sector in Sub-Saharan Africa as:

1. Already, 60% of health financing is from private sources.
2. Also, 50% of health expenditure is spent on private providers.
3. Rapid economic growth is set to expand the African middle-class, increasing the capacity to pay for care and consequently the demand for good quality services.
4. Demand is also increasing due to new developments in the health sector, such as the emergence of generic drugs, low-cost insurance and medical tourism.
5. The public sector is unable to meet even current demand because of a shortage of capital and human resources and problems with efficiency and quality.
6. External funding is also stagnating.
7. The private health sector has the means to address this gap and offers good returns on investment, particularly as stability and good governance grows on the continent.
8. Both businesses and country health systems can benefit from a stronger private sector.

With respect to **financing**, the literature reveals the entry of new foreign and domestic private investors into the health care sector, as well as the provision of new types of loans, both directly or indirectly through local banks. The new *Health Insurance Fund* and *Africa Health Fund* bring together development funding (from governments and external funders) with funds from business to provide 'seed' money for new private health care initiatives. With respect to **ownership**, emerging enterprises are either entirely private (sometimes from privatisation of existing public services) or public-private partnerships based on contracts.

Three **components of the health sector** which this report was able to investigate are hospital care, risk-pooling arrangements and pharmaceuticals (data constraints precluded investigating other dimensions). With respect to hospitals, there seems to be a trend towards high-end, 'boutique' hospitals that target the high-income, expatriate, diplomatic, NGO and medical tourism markets. Another trend is towards high-volume hospitals that serve middle- and low-income patients. With respect to risk-pooling arrangements, private health insurance is being strongly promoted in several countries, like South Africa. Lastly, pharmaceutical multinationals reportedly see future growth resting on expansion into Africa.

These developments indicate that:

- Even very poor or countries with recent conflict have received new investments in the private health care sector.

- There is more private sector activity in some countries, eg: Kenya, Uganda, Tanzania.
- The private sector-oriented NGO, PharmAccess, has wide influence, with involvement in two funds investing in private health care and various private health insurance initiatives.
- Several South African companies are expanding into the rest of the region.

Backing for an increased role for the for-profit private health emanates not only from the IFC, but also from other international agencies and initiatives such as the World Health Organisation (WHO), USAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Bill and Melinda Gates Foundation, as well as Western governments, such as the United Kingdom and the Netherlands. Governments within east and southern Africa have also encouraged private sector investment. The South African experience, on the other hand, raises questions about the beneficial impact of the for-profit private sector. In South Africa, de-regulation in the late 1980s saw the proliferation of private health insurers, fragmentation of risk pools, reduced income and health cross-subsidies, rising costs for health insurance premiums, rising fees charged by private providers (especially by hospitals), declining coverage, increased vertical integration (resulting in declining competition), capturing of public subsidies by the private sector and skilled health professionals being attracted away from the public sector. These trends have proved very difficult to reverse during the 2000s.

This experience challenges the assumptions behind the IFC report, especially with respect to the impact of the private sector on health care coverage and the integrity of the health system. It suggests it is unwise for governments (and external funders) to encourage the unfettered expansion of the private for-profit sector without, first, considering both the benefits and the unintended consequences and, second, putting in place appropriate regulation (together with the capacity to evaluate and enforce it). Governments need to consider features that may lead to private sector expansion not supporting social objectives:

- Still limited evidence on the impact of the for-profit private sector, not least because of limited information from private enterprises, making it difficult to monitor their impact.
- Weak policy frameworks and limited regulation of the private sector making it difficult for governments to manage and oversee private sector expansion.
- Contractual relationships often unfavourable to governments in terms of the sharing of risk and difficulties for government to penalise companies that violate contracts.
- Private sector capture of public subsidies.
- Escalating costs associated with private sector expansion, even where private sector initiatives have been designed to cut costs.
- Increasing consolidation of companies, verticalisation of components of the health care market and the entry of large foreign companies has so far restricted competition.
- Erosion of the public sector associated with increased private sector activity through, for example, the fragmentation of risk pools and the brain drain of public sector personnel.

Given these concerns Ministries of Health need to highlight both benefits and pitfalls of encouraging for-profit private sector provisioning in economic growth policies and assess the opportunity costs of supporting the for-profit private health sector as opposed to developing the public health system. This calls for health impact assessments before investments, especially where government subsidies or external funds are involved, evaluation of the impact of private sector activities on core social objectives and monitoring of these investments. Comprehensive policies on the private sector need to be developed, together with a robust regulations and state capacities to monitor private sector activity and enforce regulations and sanctions. Governments need to act firmly against the development of monopolies and unethical business practices and prioritise activities that improve coverage in rural areas and low-income populations. For Ministries to gain support for these approaches, especially amongst external funders, it is essential that they provide a good quality alternative to for-profit private health care. This requires injecting adequate resources into the public health system as well as revitalising management systems.

1. Introduction

A 2009 discussion paper of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) on the commercialisation of the health sector in East and Southern Africa concluded that, overall, new private investment in the region had been minimal, at least until 2007 (Ruiters and Scott 2009). Botswana, Mauritius, Namibia and South Africa appeared to be the growth points for private investment, with the latter clearly the dominant country. Other countries experienced very low, uneven and sometimes declining levels of investment.

In 2007, however, a report was published by the International Finance Corporation (IFC) which is part of the World Bank Group. Entitled *The Business of Health in Africa: partnering with the private sector to improve people's lives*, the report argued that expanding the private health sector would be good for both investors and country populations (IFC 2007). Whilst acknowledging the need for appropriate regulation, the report encouraged governments and external funders (donors) to facilitate private sector expansion through more business-friendly policies and subsidisation of private sector initiatives.

This report was commissioned by EQUINET to highlight 'policy challenges of commercialisation and private for-profit involvement in the health sector in East and Southern African countries.' As indicated by the terms of reference, the focus of the report is *the formal, for-profit sector*. This is because, if unregulated, large-scale commercial enterprises have considerable potential to impact negatively on equity and destabilise the health system, as shown by the international literature critiquing the commercialisation of health care (see, for example, Mackintosh and Kovalev 2006) and the experience of South Africa since the 1990s (see, for example, McIntyre 2010). This is not to say that the informal, for-profit and non-profit sectors are not also capable of impacting negatively on health systems. On the contrary, interventions to improve the quality of care offered by the informal, for-profit sector in Sub-Saharan Africa are required urgently, especially in countries where the public health system is very weak (see, for example, Goodman, Brieger et al. 2007). Research on these sectors is thus certainly necessary but beyond the scope of this report.

As much of the IFC report was also addressed to the formal, for-profit private sector, this report uses the IFC's conceptual framework to structure its analysis. The report first summarises the rationale behind the IFC's recommendations and the opportunities for private sector investment that it identified. It then explores whether there are signs of increasing private sector activity in the region. The report then goes on to alert regional Ministries of Health and external funders to issues for concern based on regional experience of private sector activity in the past.

The body of the report identifies recent trends in the private sector in broad terms while the *Annex* provides specific examples of recent private initiatives in the region. The focus is on initiatives since 2007 although some data are from slightly before this date, depending on the source of evidence.

2. Methods

This report is based on a rapid desk-based search of the predominantly grey literature on for-profit private sector activity in the health sectors of East and Southern Africa. Initially key words such as 'private health sector' or 'private hospital' were entered together with 'Africa' or individual country names into PUBMED and Google, with a focus on the last five years. As initial sources were identified, the search was refined by entering the names of private companies, funds and other institutions involved in commercial activities. Leads from

company reports or industry newsletters were also followed up. Given resource constraints, only references relating to types of private financing, health care provision, risk-pooling arrangements and pharmaceutical manufacture and distribution were pursued. In any case, these account for the bulk of private sector investment opportunities (IFC, 2007).

Information on other activities, such as the manufacture and distribution of medical products and IT systems, retail activities and health professional education has therefore been excluded although they certainly warrant research in their own right. This report is therefore only an initial scoping exercise that needs to be followed up by more detailed and systematic research. It is not able to provide a comprehensive overview of recent commercial activity in the region or the level of investment. As the report relies exclusively on secondary data, and much of the data are not from peer-reviewed sources, the reliability of the data may be questionable in some cases. However, some data are from reliable sources, in some cases it has been possible to triangulate data and, as a whole, the data are able to suggest areas for further investigation.

3. The IFC's case for expanding the private health sector

The IFC report rests its case for the expansion of the private sector in Sub-Saharan Africa on the following argument:

1. Already, 60% of health financing is from private sources.
2. Also, 50% of health expenditure is spent on private providers.
3. Rapid economic growth is set to expand the African middle-class, increasing the capacity to pay for care and consequently the demand for good quality services.
4. Demand is also increasing due to new developments in the health sector, such as the emergence of generic drugs, low-cost insurance and medical tourism.
5. The public sector is unable to meet even current demand because of a shortage of capital and human resources and problems with efficiency and quality.
6. External funding is also stagnating.
7. The private health sector has the wherewithal to address this gap and offers private investors good returns on investment, particularly as political stability and good governance practices emerge on the continent.
8. Therefore, both businesses and country health systems can benefit from a stronger private sector.

In presenting this argument, the IFC report notes that the private sector is made up of both formal and informal components and that each of these consists of for-profit organisations, social enterprises (or 'not-for-profits') and non-profit organisations. (Social enterprises are businesses whose social purpose is central to their operation. Profits are used more to further social aims than to maximise shareholders' returns on investment). It also acknowledges that these different components may be driven by different incentives. However, the report does not differentiate clearly between different components when presenting its analysis of successful private sector case studies. At the same time, many of the conclusions, and much of the language of the report, are addressed to the formal, for-profit private sector, for instance, through frequent references to 'investment' and 'returns on investment,' as well as the very title of the report, *The Business of Health in Africa*.

4. Opportunities for private investment in the health sector

The IFC report identifies the health sector as one of the top-five most promising investment areas in Africa, expanding at the rate of the telecoms or infrastructure sectors (Rundell 2010). According to the IFC, 'for health care companies looking for markets in which to expand, and for investors looking to invest in health care businesses, this [projected] \$11–

\$20 billion in private health care expansion [in Sub-Saharan Africa] represents a significant opportunity' (IFC, 2007:15). About 60% of these expansion opportunities could attract for-profit investors.

The IFC identifies five sub-components of the health sector that are attractive to private investors:

- health services provision (outpatient and inpatient), representing 50% of current investment opportunities;
- risk-pooling arrangements, representing 13%;
- life sciences-related activities (pharmaceuticals and medical products), representing 14%;
- retail and distribution, representing 14%; and
- medical and nursing education, representing 9% (IFC, 2007).

These sub-components are described in detail in *Table 1* which provides a useful framework for understanding investment opportunities in the health sector. Most opportunities are for small- and medium-sized enterprises (except for manufacturing of pharmaceuticals and medical products which attract large investments). For-profit examples of existing enterprises from the East and Southern African region that were quoted in the IFC report are included in *Table 1*.

Table 1: Investment opportunities in the for-profit health sector in East and Southern African countries

Investment opportunity	Description	Country examples
Health services provision		
Small, high-end hospital (profits can be 30%)	'boutique' hospital located in urban area, providing high quality care and targeting the wealthy and expatriates	Tanzania: Tanzania Heart Institute in Dar es Salaam
Network of primary and secondary clinics	integrated set of facilities extending into lower-density areas, sharing overhead costs, management expertise and procurement systems; economies of scale allow specialised services to be delivered	Uganda: Clinic Africa
Hospital offering in-house insurance	offers own insurance scheme to families where the catchment population is uninsured; requires reinsurance or external funder subsidies to manage risk	Uganda: Kadic Hospital
High-volume, low-cost hospital	located in high-density area, providing basic care and targeting low-income people (patient through-put can be up to 100 patients per doctor per day); sometimes specialises in one type of service (e.g. cataract surgery)	–
Hospital with cross-subsidisation model	fees differentiated by patient income, with better hotel services provided to patients paying higher fees; quality of care supposedly not differentiated by fee level	Uganda: International Hospital in Kampala
Large diagnostic laboratory	diagnostic laboratory providing diagnostic services to geographic area that can be quite wide-ranging	–
Telemedicine	doctors in urban area provide advice to clinic nurses by phone or internet, particularly in rural areas where there is a shortage of doctors	–
Specialised doctors covering network of hospitals	group of specialists travels between facilities with equipment to treat pre-booked patient; in areas where there is a shortage of specialists	–

Investment opportunity	Description	Country examples
<i>Risk-pooling arrangements</i>		
Indemnity insurance within general insurance	health insurance offered by general insurers with a fee based on risk profile	Tanzania: Strategis Kenya: CFC Life Uganda: Cooperative Insurance
Health maintenance organisation integrated with service providers	organisation providing insurance coverage together with access to selected providers, using managed care principles	model fairly developed in Namibia and Zimbabwe
Micro-health insurance associated with micro-finance institution	health insurance sold together with micro-finance products	–
<i>Life-sciences related activities (pharmaceuticals and medical products)</i>		
Generics manufacturing	formulation of generic medicines (prescription and over-the-counter)	South Africa: Aspen Pharmacare (70% of sub-Saharan Africa's annual pharmaceutical production)
Medical supplies manufacturing	manufacturing of medical supplies (e.g. long-lasting mosquito nets, medical gauzes, medical furniture)	–
Life sciences innovation (South Africa)	financing innovation and commercialisation of local research outputs	Almost exclusively South Africa (e.g. Bioclones, Disa Vascular)
Commercialisation of infectious and neglected disease research	financing commercialisation and local application of research conducted globally	–
<i>Retail and distribution</i>		
Pharmacy chains (most profitable opportunity e.g. 50%)	consolidation of individual outlets into chains that compensate for lower margins (usually as a result of government regulation) with volume	Uganda: Vine Pharmacy
Multi-sector distribution platforms	shared transport of pharmaceuticals (especially over-the-counter medicines) with soft drinks and consumer goods	Tanzania: Nufaiika
Multi-brand, vertically integrated platforms	integration of different components of the supply chain, sometimes paired with distributing several different brands	Sub-Saharan Africa: Fuel Africa (part of South African Fuel Group) South Africa: PHD
Pharmacy accreditation programmes for informal retail operators	private company managing accreditation programme	–
Supply chain management programmes for external funders or governments	private company managing supply chain	–
<i>Medical and nursing education</i>		
Large, multi-discipline university	(self-evident)	–
Schools for nurses, midwives and lab technicians	(self-evident)	–
Distance learning: nurses	(self-evident)	–

Source: Adapted from IFC, 2007

Although the IFC report is not explicit about how private entities could become involved in **financing** the African health sector, the most common likely models are foreign and domestic direct investment or the provision of loans (otherwise known as debt financing), both directly to local companies or through local banks. Private equity funding could be stand-alone or twinned with external or government funding.

Ownership could be entirely private through the creation of new institutions or arise through the privatisation of existing public services. Alternatively, private-public partnerships could be set up, examples being where private enterprises: undertake specific functions on behalf of the public sector through service contracts; manage publicly-owned health facilities through management contracts (usually for between two and five years); rent and upgrade existing public health facilities through lease contracts; or provide substantial new capital to public establishments and use the refurbished facility for a specified time, usually ten years or more (a concession contract).

5. Changing private sector investment patterns in East and Southern Africa

This section looks at whether, despite the global economic recession, there are signs that the opportunities identified by the IFC have been taken up in recent years, especially since 2007. The section begins by identifying some new private financing initiatives and then goes on to present some examples of new investments in the formal, for-profit health care sector. With respect to the latter, and as indicated earlier, resource constraints have meant that this report is only able to focus on the components of health care provision, risk pooling and pharmaceutical manufacture and distribution.

The *Annex* provides more details on the initiatives described in this section, as well as some other initiatives. This inventory is incomplete because of data limitations and is only a first step towards understanding the range of private sector initiatives in the region.

5.1 New private financing initiatives

New private financing initiatives include:

- the creation of development funds focused on the private sector;
- private equity funds; and
- the provision of debt financing.

In 2005 a fund was established in the Netherlands to bring together development funding (from governments and external funders) with funds from the private sector. The **Health Insurance Fund**, which is supported by the Dutch Ministry of Development Cooperation, is intended to provide a mixture of public, external and private funding to stimulate private health insurance companies, creating a demand for private provision. PharmAccess, a Dutch NGO, has been appointed to manage the Fund and is very active in developing models and contracts to facilitate private health insurance. The **Africa Health Fund** was launched in 2009 by the IFC. It is backed by four investors - the IFC, the African Development Bank, the Deutsche Investitions- und Entwicklungsgesellschaft (DEG) and the Bill & Melinda Gates Foundation. DEG is part of a banking group. It finances investment by private companies in developing countries. These have provided 'seed' funding to encourage other investors – both external funders and private companies - to contribute.

The Fund seeks to invest in private businesses that provide affordable, high-quality health care services to low-income populations whilst at the same time providing satisfactory long-term returns to investors. It also aims to provide technical support. In 2010 the Fund's first

investment was acquiring a stake to the value of US\$2.66 million in the Nairobi's Women's Hospital with the aim of expanding its services in the region. The hospital reportedly provides substantial health care to poorer populations.

Private equity funds are reportedly examining the African health care sector as a potential source of profit, rather than just an avenue for social responsibility programmes (Mbogo 2010). Increasing investment from international companies is expected. For example, the US-based hedge fund Harbinger Capital Partners has bought a controlling stake in African Medical Investments which aims to become a leading operator of high-end hospitals.

The Netherlands-based **Investment Fund for Health in Africa** was established in 2007 and provides private equity to invest in private health providers. It is a private equity fund that provides long-term capital to small and medium enterprises. Amongst its shareholders is Pfizer. Projects include a pharmaceutical wholesale and distribution company and a private health insurance company, Strategis, in Tanzania. In 2010 it purchased a 20% stake in a private insurance scheme, AAR East Africa, that is based in Kenya but operates in many other countries in the region.

The **Medical Credit Fund**, which is also co-ordinated by PharmAccess, the Dutch NGO coordinating the development fund described above, provides debt financing to private providers, primarily in the primary care sector (private GPs and dispensaries). Established in 2009, the fund provides loans through local banks, as well as technical advice, to private primary care facilities and dispensaries in Africa, including Tanzania and Kenya. In return, practices are required to upgrade their facilities and services. A seemingly separate programme was started in 2007 in Zambia to expand access to finance for the private health sector (McKeon and Musona 2009).

5.2 Increasing investment in profitable components of the health sector

Several trends in **hospital care** are apparent. First, international private investors – such as the Indian hospital group Fortis Healthcare and the private equity company African Medical Investments which is based in the Isle of Wight - are expressing interest in funding high-end, 'boutique' hospitals that target the high-income, expatriate, diplomatic, NGO and medical tourism markets. These hospitals make no pretence at serving lower-income populations. Start-up countries include Kenya, Mauritius and Tanzania. Even Mozambique has seen the opening of one of these hospitals, despite it being one of the poorest countries in the region. African governments are reportedly actively seeking such investments.

Second, some South African private hospital networks seem to be preparing to expand into the region. While Medi-Clinic already has a presence in Namibia it appears to be concentrating its current expansion in Switzerland and the Gulf States, but Netcare has recently embarked on an IFC-brokered public-private partnership at a hospital in Lesotho (reportedly as the first step in expanding into other areas of the region) while the IFC has bought a stake in Life Healthcare to help it transfer management expertise to other African countries. Third, the IFC has become active in promoting private hospitals elsewhere in the region. For example, in Uganda it has facilitated a loan to a private hospital owned mainly by private specialists working at the hospital. At this hospital, laboratory services are contracted to a South-African linked company, Lancet.

In terms of **primary care**, it was very difficult to find information on individual practitioners. However, McKeon and Musona (2009) note that, in Zambia, although the formal private sector is small, recent years have witnessed a sudden growth with around 23% of 432 registered medical providers having started their practices between 2004 and 2006.

With regard to **risk-pooling arrangements**, the heavy reliance of African health systems on out-of-pocket payments has long been criticised because this form of financing is the most inequitable and exposes households to catastrophic financial risk at the time of illness. In recent years private health insurance has been promoted as an alternative, by PharmAccess and the IFC in particular, because it encourages prepayment and the pooling of health risks. Private health insurance is seen as providing business opportunities to private companies administering the insurance scheme as well as stimulating the market for private health care providers. Third party payments are also seen as reducing the risks to private providers of non-payment of fees by their clients (McKeon and Musona 2009). Collective insurance that targets whole communities, rather than individual health insurance, is being promoted. With time it is hoped that private health insurers can form the basis for the development of more extensive social health insurance. This approach (as opposed to developing social or national health insurance) appears to have been driven largely by institutions based in the Netherlands where, historically, universal coverage emerged on the basis of this model. It appears that early experiments with private health insurance are beginning in Tanzania on the back of earlier experience in Namibia and Nigeria. Some funding has been provided by the Health Insurance Fund and the process is being overseen by PharmAccess. The local implementing partner is the private health insurer Strategis that was registered in 2003 and is reportedly growing rapidly. The South African general insurance company, Liberty Holdings, is also reportedly set to expand its activities into neighbouring countries.

Pharmaceutical manufacture and distribution is also growing in Africa. Rundell (2010) notes that 'most multinational drug companies are now targeting Africa for their next growth phase.' It is beyond the scope of this report to detail all of these initiatives, most of which build on the pre-existing presence of these multinationals. Interestingly though, India and China have become prominent exporters of pharmaceuticals to South Africa (Kudlinski 2009): this probably signals a change in the range of companies present on the continent. It is worth singling out the case of the South African company Aspen Pharmacare. Box 1 shows its rapid growth in the region through diversifying its product range, buying a stake in existing regional companies and developing a partnership with GlaxoSmithKline.

Box 1: The regional growth of Aspen Pharmacare

Aspen was founded in 1997 and enjoyed a 40% per annum growth in its first decade. In 2008, the value of its manufacturing facilities – in South Africa, Kenya and Tanzania - was over R1 billion. Within South Africa Aspen is the top manufacturer of generics while, worldwide, it is one of the top 20 generics manufacturers. Initially Aspen was principally associated with the provision of drugs for the treatment of chronic diseases, especially HIV and AIDS and TB. Today, however, it supplies branded and generic drugs, as well as nutritional and consumer products: this diversification is partly due to declining returns it experienced on generics with the entry of Chinese and Indian generics manufacturers into the African market. Starting in 2005, the South African Department of Trade and Industry has made Aspen a beneficiary of its Strategic Investment Programme, a government policy to entice investors into new business concerns – including the pharmaceutical sector - through the granting of tax relief in the form of a capital allowance. In 2010 this lowered Aspen's tax bill by R46 million. While Aspen's activities in Sub-Saharan Africa only contributed 9% of group revenue in 2010, it is actively seeking to expand its activities in the continent. This expansion appears to be founded on two main strategies. First, in 2008 Aspen acquired a 60% interest in the ailing Tanzanian Shelys. Second, in 2009 GlaxoSmithKline, which is the world's second largest seller of prescription drugs, acquired 16% of Aspen's shares, and a non-executive director on its Board. This was in exchange for:

- giving Aspen the rights to market, sell and distribute GlaxoSmithKline's pharmaceutical products in South Africa for a minimum of 20 years;
- collaborating with Aspen in the marketing and selling of pharmaceuticals¹ to Sub-Saharan Africa under the brand 'The GSK Aspen Healthcare for Africa Collaboration' (most of the combined sales were formerly by GlaxoSmithKline);
- giving Aspen the rights to eight specialist branded products for worldwide distribution; and
- giving Aspen GlaxoSmithKline's manufacturing facility in Germany which produces some of the products that have been divested.

Source: See Annex

5.3 Overall trends in the region

Data limitations mean that only tentative conclusions can be drawn from the inventory of new private sector initiatives described above and in the *Annex*. It must be kept in mind that there may well be other important initiatives that have not been reported in the press, studied by other researchers or identified by this review. Using what information is presently available, *Table 2* shows, first, that taken together there does seem to be a number of new for-profit initiatives in East and Southern Africa. These initiatives span the range of private sector sub-components that are the focus of this report, although it is least clear what is happening with respect to private general practitioners and specialists. Even very poor or recently war-torn countries are receiving these investments, some of which are for high-end 'boutique' hospitals.

New private sector activity seems to be vigorous in some countries in particular, namely Kenya, Uganda and Tanzania (see *Box 2* for a case study of Kenya). Why this is so, is a matter for speculation. Reasons could include the presence of a good skills base, business-friendly policies and deregulation of the health system (McKeon and Musona 2009; Ruiters and Scott 2009). The efforts of international agencies must not be discounted. For example, in Zambia, apart from the IFC, the USAID-funded Banking on Health project was active in designing a programme to finance and support the sustainable delivery of reproductive health and family planning services in the private sector (McKeon and Musona 2009).

Box 2: Private sector expansion in Kenya

The value of the health services industry in Kenya has risen steadily from Sh33 billion in 2004 to Sh51 billion in 2008. A recent newspaper report estimated that private equity's interest in private hospitals has more than tripled in the past two years and is expected to peak at no less than Sh1 billion by the end of the year. Private equity funds account for Sh500 million in the past two years, a growth from zero in 2007. Foreign private enterprises' interests in Kenya has been rising steadily from five in early 2000 to an estimated 25 currently.

Thus, for example, in 2008 TBL Mirror Fund BV purchased a significant stake in Meridian Medical Clinics that operates medical facilities providing outpatient medical services. This helped the chain increase from 3 to 10 private clinics. The TBL Mirror Fund provides venture capital, entrepreneurial expertise and access to an international investor network for small and medium Kenyan enterprises. The company is based in Nairobi, Kenya. Kenya was one of the first countries that the IFC-World Bank Health in Africa initiative chose to work in. In January 2010, Aureos Capital, which manages the Africa Health Fund, bought into Nairobi Women's Hospital for Sh200 million (\$2.66 million). Nairobi Hospital then bought Masaba Hospital to extend its services: this is now known as The Nairobi Women's Hospital-Adams. The hospital is also looking for private equity funds to boost its expansion plan. More than half the services of the hospital are for the poor. An unknown private equity fund is also in talks with Karen Hospital in Nairobi to expand its presence in the region. As historically Kenyan hospitals have tended to only seek modest returns, the introduction of investors with a profit motive may signal price increases.

The few private insurers in existence are serving only the high end of the market. The private health insurance sector in Kenya is still relatively small, covering about 2% of the population, mostly high-income groups working in the formal sector. There is strong interest in developing low-income private insurance. However, Kenya is also implementing an NHI fund pilot. Acumen Fund (a non-profit venture capital fund that favours social projects) has bought a stake in a new eye hospital and a pharmaceutical franchise of low-cost pharmacies. It is also planning to invest in a hospital in 2011. In general the pharmaceuticals sector is growing rapidly and was expected to have double-digit growth in 2010.

Sources: Barnes, O'Hanlon et al. 2010; Mbogo 2010; Michira 2010; Minney 2010; Steave 2010

In addition, the private sector-oriented NGO, PharmAccess, appears to have very wide-ranging influence in the region.

Another noted trend is that several South African companies are amongst those expanding into the rest of the region. South Africa's regional dominance may be measured in medical supplies, equipment and drugs which comprised almost 10% of high technology exports to the Southern African Development Community in 2008 with Tanzania, Zimbabwe and Mozambique being major recipients (Ruiters and Scott 2009). It seems that recent South African investment has been driven by a powerful push-pull combination of saturation of the domestic market, relatively high profit margins in regional markets, a relative lack of interest by multinationals in competing for markets in the region, the economies of scale presented by large South African companies, liberalised conditions for the repatriation of regional earnings by South African companies and stronger regulation in South Africa pushing capital over the border (Ruiters and Scott 2009). Fears in South Africa that the proposed National Health Insurance system might curtail opportunities for private providers may also be contributing to this trend.

Finally, Ruiters and Scott (2009:2) note that, 'even if the FDI dries up, internal shifts in the health sector within countries, even those not regarded as good investment options, are very significant as Zimbabwe and Tanzania show.'

Table 2 overleaf gives examples of recent or planned private sector initiatives in east and southern Africa.

6. Issues in private sector expansion

Clearly, backing for an increased role for the private health sector - especially the for-profit component - emanates not only from the IFC, but also from other international agencies and initiatives such as WHO, USAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Bill and Melinda Gates Foundation, as well as development-oriented Western governments, such as the United Kingdom and the Netherlands (Ruiters and Scott 2009). In addition, a World Bank-IFC report that has just been published has begun to address how relationships between governments and the private sector could become more structured (World Bank and IFC 2011).

Governments within the East and Southern African region have also begun to seek private sector investment more actively. Thus, for example, in 2010 the Zimbabwean government launched an appeal for additional funding to the tune of \$700 million in order to raise per capita spending on health care from \$9 to \$34. The appeal was backed by WHO, UNICEF and the World Bank and included a call for the investment of private funds (Associated Press 2010). Mauritius is also actively inviting Indian investors to invest further in the country as part of its strategy to become the destination of choice for 'medical tourism' (Bhuckory 2011).

The South African experience, on the other hand, raises questions about the degree to which expansion of the for-profit private sector benefits the general population and the health system as a whole. In South Africa, de-regulation in the late 1980s saw the proliferation of private health insurers, fragmentation of risk pools, reduced income and health cross-subsidies, rising costs for health insurance premiums and private health care provision (especially by hospitals), declining coverage, increased vertical integration (resulting in declining competition) and capturing of public subsidies by the private sector (Doherty and McCleod 2003; Doherty and Steinberg 2003; McIntyre 2010). The expansion of the private sector, together with higher fees, attracted skilled health professionals away from the public sector. At the end of the 1990s, around 75% of specialists, between 50% and 70% of GPs and around 40% of nurses were estimated to work in the private sector.

Table 2: Examples of recent or planned private sector initiatives in the countries of East and Southern Africa

Country	Mixed development finance and private equity funds		Private equity funds	Debt financing	Pharmaceutical companies		Private hospital groups					General insurer	Health insurer	Private sector-oriented NGO
	Africa Health Fund	Health Insurance Fund	Investment Fund for Health in Africa	Medical Credit Fund (and others)	Aspen Pharmacare (with Smith Glaxo Kline)*	Shelys	Africa Medical Investments – VIP Health-care Solutions	Fortis	Life-care**	Medi-clinic	Net-care	Liberty Holdings	Strategis	Pharm-Access Foundation
Angola	(✓)													✓
Botswana												(✓)		
DRC	(✓)					✓	(✓)							✓
Kenya	✓		✓	✓	✓	✓	✓							✓
Lesotho											✓	(✓)		
Madagascar														✓
Malawi						✓								✓
Mauritius					✓			✓						
Mozambique	(✓)						✓							✓
Namibia		(✓)								✓		✓		✓
Rwanda	(✓)		✓			✓	(✓)							✓
South Africa	(✓)				✓				✓					✓
Swaziland											(✓)			
Tanzania	(✓)	✓	✓	✓	✓	✓	✓						✓	✓
Uganda	(✓)		✓		✓	✓	(✓)							✓
Zambia	(✓)			✓		✓					(✓)			✓
Zimbabwe							✓				(✓)	(✓)		✓

*The company has manufacturing plants in these countries but markets to many other countries

** Not clear where in Africa this company will be expanding

✓ Institution is currently in this country

(✓) Institution is planning to expand to this country

Where cells are empty, there are no plants and no future plans

While in the 2000s there were some hard-won achievements in regulating the practice of dispensing doctors, setting single exit prices for pharmaceuticals, controlling dispensing fees and re-regulating the medical schemes industry, private providers remain largely unregulated in terms of their geographic distribution, fees, reimbursement mechanisms and treatment patterns (despite expensive managed care initiatives).

This suggests it would be unwise for governments to encourage the unfettered expansion of the private for-profit sector without, first, understanding both the benefits and unintended consequences and, second, putting in place appropriate regulation (together with the capacity to evaluate and enforce it). This section identifies particular issues for concern, drawing on the South African experience but also supplementing it with emerging evidence from other countries in the region.

6.1 Limited information on the impact of the for-profit private sector

The IFC report argues that a stronger private sector would offer advantages to the health systems of countries. For example, it would introduce new management skills, raise standards of care, help to stem the brain drain from Africa by creating pleasant, well-paying work opportunities, and develop human resources.

However, the IFC report does not differentiate clearly between the for-profit and non-profit private sector when putting forward these arguments. This is problematic, for example, when the report argues that the private sector will improve health care coverage, including for low-income communities, because the models it quotes to substantiate this view tend to veer towards the social enterprise - or even non-profit – side of the spectrum. Further, the report uses the current size of the private sector as justification for its policy relevance, without indicating that the for-profit component is relatively small, serving only a fraction of the population that tends to be better-off.

Neither does the report present hard evidence on the impact of the private sector, whether for-profit or non-profit. Case studies are presented but the evidence on which they are based does not seem to be publicly available. Indeed, internationally there is little systematic and comprehensive information on the impact of the private sector on key social objectives (including affordability, equity, efficiency, sustainability and quality) or the integrity of the health system, a problem aggravated by the fact that for-profit entities are often unwilling to disclose information that would allow proper comparisons to be made with public and NGO institutions.

Further, governments find it difficult to monitor the for-profit private sector because of shortfalls in capacity. Zimbabwe is a case in point as, despite having introduced regulations to control the behaviour of medical aid societies, the office in charge of regulation is unable to monitor the industry because of a shortage of personnel (Shamu, Loewenson et al. 2010). In some cases monitoring does not happen because of a lack of awareness that the activities of the private sector are relevant to public health policy, as was the case in South Africa during the 1990s (McIntyre 2010).

Evidence on impacts should be a pre-requisite for embarking on reforms the size of that envisaged by the IFC report, including a better understanding of the causal pathways through which a stronger for-private health sector is supposed to improve the health of a country's population as well as equity. Embarking on a reform without sufficient evidence was a feature of another form of commercialisation, the introduction of user fees to government facilities in the 1980s, a reform which had negative impacts on access and utilisation and which is currently being reversed in several countries.

6.2 Weak policy frameworks and limited regulation

Typically governments in the region have not developed coherent, overarching and implementable policy frameworks on the for-profit private sector (The World Bank and the International Finance Corporation 2011). This applies even to South Africa where there has been considerable activity with respect to policy development on sub-components of the sector.

Where there is regulation, this is often weak or poorly implemented. This has been the case with the medical aid societies in Zimbabwe where medical aid societies have defaulted on obligations to provide annual financial reports to the Registrar and hold annual advisory council meetings (Shamu, Loewenson et al. 2010; TARSC, SEATINI et al. 2010). Poor implementation of regulations is also reportedly a problem in Kenya (Barnes, O'Hanlon et al. 2010), a country witnessing rapid expansion of the private sector.

A complication in terms of regulation of the private sector is the interface between health policy and policy on free enterprise. Whereas Competition Commissions in South Africa and Zimbabwe have acted against collusion in the setting of prices by private hospital groups and the vertical integration of funders and providers respectively, these actions have been based on economic arguments rather than on the welfare of patients. Thus, for example, the South African Competition Commission ruled that the association of medical schemes should not be allowed to set tariffs for reimbursement of private hospitals and other providers, undermining the main tool available to medical schemes (and government) to control cost escalation.

It is worrying that the IFC report calls for further de-regulation of the private sector in order to improve profitability, even as it acknowledges that regulation is required to protect the quality of care.

6.3 Contractual relationships unfavourable to government

When engaging in public-private partnerships, governments often find themselves agreeing to terms that are unfavourable in terms of the distribution of risk between the two parties. They also find it difficult to impose sanctions when the terms of the contract are violated. This has been well-documented in the international literature and was a large problem in South Africa in the early 1990s (Monitor Company, Health Partners International et al. 1996).

In the light of this experience it is worrying that such partnerships are being promoted actively by the IFC and other international agencies, in the absence of evidence on clear mechanisms for ensuring that contracts are fair and binding and that these mechanisms are sustainable. Recent projects of the IFC, such as the awarding of a long-term contract to Netcare to modernise and run the Queen Elizabeth II Hospital in Lesotho, presumably aim to test such mechanisms by providing support to the Lesotho government.

6.4 Subsidising private concerns with public money

The experience of South Africa highlights the extent to which private institutions and health insurance beneficiaries have captured public subsidies (see *Box 3*). In that country, government subsidises its own employees to receive private care by an amount greater than it spends on public sector dependents. As Marriott (2009:3) notes, this is an example of how 'attracting private providers to low-income risky health markets requires significant public subsidy.' It is worrying, therefore, that a new brand of public-partnership is emerging in Africa where the risk faced by private investors is explicitly reduced by providing financial backing

from government and external funder sources. This could lead to governments shouldering an unfair degree of risk whilst subsidising profits made by private investors.

Box 3: Public sector subsidy of the private sector in South Africa

- Almost 10% of the government hospital budget was on service contracts with the private sector. These contracts were often on terms that were not favourable to government.
- The same applied to arrangements with 'district surgeons,' private GPs contracted to provide private health care to the poor on a fee-for-service basis.
- Private patients using public facilities were under-charged.
- Employers were given tax relief for contributing to their employees' medical schemes. In 2005, the value of this tax subsidy was equivalent to 20% of the public sector health budget.
- Government paid high premiums for its civil servants who belonged to medical schemes. In the 1990s it spent 12 times as much per civil servant than it did on public sector dependants.

Sources: *Monitor Company, Health Partners International et al. 1996; Doherty, Thomas et al. 2002; McIntyre, Gilson et al. 2006*

6.5 Escalating costs

Like any other business sector, the for-profit private health care sector is driven by the need to make money out of the services it provides. What seems to be increasing involvement of banks, insurance companies and private equity funds in the African private health care sector seems to testify to this.

Financial imperatives in the private sector are fundamentally different from the main objective driving public health systems and often lead to escalating costs, a perennial problem in South Africa. In Zimbabwe, medical aid societies had argued that the integration of their funder and provider business arms would allow them to contain costs, but costs have risen nonetheless (Shamu, Loewenson et al. 2010). In Kenya, private sector prices have been rising by 20% on an annual basis due to the collapse of agreements on pricing guidelines (Barnes, O'Hanlon et al. 2010). This has led to the introduction of co-payments which were almost unheard of a few years ago. In other countries, another strategy to cope with cost escalation is a reduction of benefits.

While the private sector often argues that higher costs relate to better quality of care, new technology and ageing populations, there is also evidence that it can be due to business tactics such as over-charging, inflated administrative and managed care costs, over-servicing and risk-rating of premiums. In South Africa, for example, inflated pharmaceutical costs due to mark-ups along the supply chain, and especially by private hospitals, have only recently been controlled through the introduction of a single exit price. In Kenya, the revenue growth in the Nairobi Women's Hospital is still being driven by pharmaceuticals and is expected to reach double-digit growth by 2014 (Mbogo 2010). In fact, the IFC report admits that private health facilities often use pharmaceutical sales to cross-subsidise their provision costs.

There is also evidence of unethical business practices that take advantage of loopholes in the law, such as collusion around prices, stripping of health insurance scheme assets and tax evasion. In Zimbabwe, for example, medical aid societies are tax exempt because of their non-profit status, despite the fact that they also own non-core businesses that are profit-making (Shamu, Loewenson et al. 2010). In South Africa a special tax dispensation has benefited large, publicly listed pharmaceutical companies so that, perversely, they face

lower tax rates than small businesses even though they support capital-intensive rather than labour-intensive manufacturing (Kudlinski 2009; Redfern 2010).

What is more, there is very little information on the quality of care (as opposed to hotel services) provided by private providers and whether this represents value for money. Almost the only failing of the private sector that the IFC identifies is problems with quality of care.

6.6 Growing monopolies and verticalisation

It has long been acknowledged that the health care market is distorted because of information asymmetry, making it susceptible to supplier-induced demand. In settings where regulation is weak, there is also vertical integration (where different companies in the supply chain are owned by the same institution), concentration (where competitors are bought out) and collusion (where competitors agree to charge similar prices). This is clear from the South African experience (see *Box 4*) but also, for example, in Zimbabwe where medical aid societies have purchased hospitals, clinics, laboratories, pharmacies, dental services, rehabilitation services, optometry services, imaging services and emergency transport (Shamu, Loewenson et al. 2010; TARSC, SEATINI et al. 2010). In Zimbabwe, beneficiaries are often required to use providers belonging to the medical aid society stable.

Box 4: Examples of vertical integration in the South African for-profit private sector

- Two of the largest private hospital groups (Netcare and Medi-Clinic) each own the two largest private emergency response groups (Netcare 911 and ER24 respectively)
- Private health care providers (doctor groupings and private hospitals) and organisations with interests in pharmaceutical and medical equipment manufacturers are investing in medical scheme administrators (particularly via Lethimvula)
- One of the largest private hospital groups (Medi-Clinic) runs the largest private health professional employment agency.

Source: McIntyre 2010

6.7 Entry of foreign countries into the domestic market

The South African private health care sector is very powerful and showing signs of expanding into the rest of the region. In fact, of the ten-member group of technical advisors that advised the IFC in the compilation of its report, three were senior executives from major South African companies (Netcare, Discovery Health and Aspen Pharmacare). Expansion is happening through Aspen Pharmacare – which, for example, has recently purchased a 60% share of the Tanzania pharmaceutical company Shelys Africa - and through other entities such as private hospital groups and laboratory services. Although indigenous companies may be more attractive options for African governments than foreign companies, it does not follow that they will necessarily introduce lower prices, judging from the South African experience.

Regional domination by South African companies is not the only threat, however: institutions from China, India, Europe and the USA are all showing interest. While more companies could lead to greater competition, as has already occurred with respect to the price of generics, alliances between different companies (such as that between Apsen Pharacare and SmithGlaxoKline) could reduce the effects of competition.

It is not clear, therefore, whether East and Southern African countries will benefit financially from new companies expanding into the region, at least to the extent intended by economic growth strategies. In addition, it is possible that some public-private partnerships (or large-scale donations such as those made by some pharmaceutical companies) which are entered into on terms favourable to governments, might be a strategy for spring-boarding companies into new markets.

6.8 The erosion of the public sector

A strong private sector can permanently undermine efforts to build a strong public sector through siphoning off skilled personnel, fragmenting the risk pool (consequently limiting opportunities for cross-subsidisation) and building power blocs resistant to regulation. It is difficult to reverse private sector expansion once it has begun, or control the behaviour of private sector stakeholders, because of the powerful business interests at stake and the weak capacity of governments.

For example, risk pool fragmentation is a current feature of the Zimbabwean situation following the expansion of medical aid societies (Shamu, Loewenson et al. 2010). It is worrying, therefore, that Dutch institutions such as PharmAccess and the Health Insurance Fund are actively promoting private health insurance as a strategy for extending coverage based on prepayment. While this model may have worked in several European countries, it does not follow that the equivalent preconditions exist in the region (such as strong governance, adequate numbers of skilled health personnel and populations that are able to afford premiums).

There is an argument that the private sector, whilst it might drain skilled staff from the public sector, at least will help to stem the brain drain overseas. This might be so but it does not necessarily follow that these staff are used to help meet the country's health care priorities. On the contrary, there is increasing evidence that the for-profit private sector largely serves the small, wealthy sector of society. Almost all of the regional examples quoted in this report are urban initiatives. As Marriott (2009) notes, data from 44 middle- and low-income countries show increasing exclusion of the poor, and most especially women, from care with increasing participation of the private sector in primary health care. What is more, the for-profit sector focuses almost exclusively on curative care and does not participate in wider public health initiatives.

7. Conclusion and recommendations

Although there are many limitations to the data gathered in this report, it appears that there may have been a discernible change in the pattern, if not the level, of private sector investment in East and Southern Africa since 2007. Given the concerns listed above, Ministries of Health should remain cautious about fostering the expansion of the for-profit private sector and entering into public-private partnerships without careful prior planning. Government policy needs to protect the integrity of the health system against financial and other incentives that distort service provision, raise prices and impact negatively on equitable access to good health care. As noted by a recent Oxfam report, 'there is considerable and increasing evidence that there are serious failings inherent in private provision which make it a very risky and costly path to take' (Marriott 2009: p2).

This means that Ministries need to:

- highlight for their own governments not only the advantages but also the potential pitfalls of encouraging for-profit private sector provision as part of their economic growth policies;
- assess the opportunity costs of supporting the for-private health sector as opposed to developing the public health system;
- require health impact assessments before encouraging for-profit private sector activities, especially those subsidised by government or external funds (focusing on the impact on health care coverage for the poor, affordability and the strength of the public health system);

- evaluate the impact of existing private sector activities on core social objectives and set monitoring systems in place;
- develop comprehensive policies on the private sector as well as a robust regulatory framework;
- develop the capacity of government to monitor private sector activity, develop policies and regulations, and enforce sanctions; and
- act firmly against the development of monopolies and unethical business practices; and
- prioritise activities that improve coverage in rural areas and low-income populations.

For Ministries to gain support for this approach to the for-profit private sector, especially amongst external funders, it is essential that they be able to provide a viable and good quality alternative to for-profit private care. This requires injecting adequate resources into the public health system as well as developing strong management systems.

Further research is also required to document the array of formal, for-profit private activities in the health systems of the region, understand the impact of these activities better and explore issues of concern with respect to the informal, for-profit private sector.

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Annex 1: Examples of private sector companies and initiatives expanding into the health sector in East and Southern Africa

The information provided in this section is as sourced in the public domain literature indicated on the date indicated. It may thus not represent the situation as of current date. The author presents what was found in the literature and attributes source, acknowledging that in a rapidly changing situation there may be differences to the current situation.

The Africa Health Fund (also known as the Health in Africa Fund)

Sources: Minney 2010; The Nairobi Women's Hospital 2010; African Development Bank Group 2011

The Africa Health Fund (also known as the Health in Africa Fund) was launched in 2009, forming part of the IFC-World Bank Health in Africa Initiative. It is a new private equity fund that seeks to invest in a wide range of sustainable private businesses that provide affordable, high-quality health care services to low-income populations whilst at the same time providing satisfactory long-term returns to investors. It also aims to provide innovative advisory services and technology.

The Fund is backed by four investors who have provided 'seed' funding to encourage other investors – both external funders and private companies - to contribute to a final target of US\$100 million by the end of 2010. The original investors have jointly invested \$57 million: the International Finance Corporation (IFC) (\$20 million), the African Development Bank (\$20 million), DEG (\$10 million) and the Bill & Melinda Gates Foundation (\$7 million). The Fund plans to make about 30 investments, ranging from \$250,000 to \$5 million and it hopes to exit from investments within five to seven years. Although viable investment opportunities from all parts of Africa will be considered, priority countries in the region include Kenya, Tanzania, and Uganda. Angola, Democratic Republic of Congo, Mozambique, Rwanda, South Africa, and Zambia are expected to follow.

In 2010 the Fund's first investment was acquiring a stake to the value of US\$2.66 million in the Nairobi's Women's Hospital. This private hospital provides outpatient and inpatient care to women and children and includes a Gender Violence Recovery Centre that is an unusual resource in East Africa. A proportion of the sum invested in the hospital will be used to help fund a management buy-out, with the balance going to the expansion of facilities such as clinics, beds, ambulances and operating theatres in the country and possibly further afield in the East Africa Region. It is not clear how investment in this hospital achieves the Fund's aim of enhancing access by the poor to improved health care.

The Africa Health Fund is managed by British private equity fund Aureos Capital.

African Medical Investments and VIP Healthcare Solutions

Sources: African Medical Investments 2010; Feller 2010; Medical Tourism News 2010; Shazar 2010; West 2010

African Medical Investments PLC was incorporated as an Isle of Man registered company in 2008 and shortly thereafter began trading on AIM, the London Stock Exchange's international market for smaller, growing companies. It is run by people who are also involved in companies investing in other sectors in Africa.

African Medical Investments was formed to invest in, or acquire, businesses that operate in the African private health care sector. Its niche is the creation of small 'boutique' hospitals and clinics

that target the African middle class and the expatriate, NGO, diplomatic and tourist markets. Its health facilities are managed and operated by AMI's wholly owned subsidiary, VIP Healthcare Solutions, which it acquired in 2008.

The company started in 2009 with its first 30-bed hospital in Dar es Salaam (Tanzania), followed by a 30-bed hospital in Maputo (Mozambique). Both include trauma centres and well-woman clinics. A trauma centre in Harare that used to belong to VIP Healthcare Solutions is being upgraded during 2010. A facility is also being upgraded for a well-man and well-woman clinic in Nairobi (Kenya).

African Medical Investments aims to rapidly roll out its facilities, with a target of 10 facilities by 2012 and 15 by 2015. African governments are reportedly contacting the company to bring facilities to their countries and the company is said to be considering facilities in Lubumbashi (DRC), Accra (Ghana), Kigali (Rwanda), Kampala (Uganda) and the DRC's Katanga province. However, it may be withdrawing from the airport medical and travel vaccination centres that VIP Healthcare Solutions used to run in Johannesburg and Cape Town, South Africa, at the time it was purchased by African Medical Investments (this may be because these facilities do not conform to the company's niche market as well as because financial irregularities have surfaced at these facilities). It is not clear what is happening to a similar clinic run by VIP Healthcare Solutions at Nairobi's Kilimanjaro airport.

Aspen Pharmacare Holdings Ltd. ('Aspen')

Sources: International Finance Corporation 2007; Aspen Holdings 2008; Woolman and Sprague 2008; GlaxoSmithKline 2009; SAinfo reporter 2009; Aspen Holdings 2010; Aspen Holdings 2010; Beukes 2010; Redfern 2010

Aspen is a South African pharmaceutical company that was founded in 1997. Within a couple of years it had taken over SA Druggists and expanded its manufacturing capacity considerably. In 2008, the value of its manufacturing facilities was over R1 billion. Aspen's rapid growth, which in its first decade was around 40% per annum, was due not only to innovative business decisions but also to a new political and economic climate in South Africa at the end of the 1990s: following protracted legal battles, multi-national pharmaceutical companies had agreed to issue 'voluntary licenses' to South African companies to manufacture generic equivalents of branded HIV and AIDS drugs still under patent, while the government had undertaken to roll out anti-retroviral therapy to its population. What is more, the South African Department of Trade and Industry made Aspen a beneficiary of its Strategic Investment Programme, a government policy to entice investors into new business concerns – including the pharmaceutical sector - through the granting of tax relief (see *Box 5*).

Box 5: The South African government provides Aspen with tax relief

In the 1990s the South African pharmaceutical sector went into decline as multi-national corporations disinvested and 37 manufacturing plants closed over a period of fifteen years. Some of the reasons for this were the availability of generic medicines, growing pressure on pharmaceutical prices, regulatory obstacles and weak incentives for investment. Domestic investment in pharmaceuticals was low and there was a growing technology gap between South Africa and high-income countries. South Africa increasingly relied on imports and became increasingly vulnerable to interrupted supplies, especially of active pharmaceutical ingredients which it had no capacity to produce internally.

Government responded by identifying the pharmaceutical industry, and especially the manufacture of generics, as a 'lead sector' under its first Strategic Investment Programme to boost manufacturing and other sectors. This Programme ran from 2002-2006 and sought to attract investors, increase competitiveness and create employment by providing tax relief to companies investing at least R50 million in innovative, wealth-creating projects. The tax benefit was an initial capital allowance of 50% or 100%, depending on the qualifying score of the investment. This allowance was additional to the normal capital depreciation allowance: together, these allowances substantially lowered the marginal effective tax rate of participating companies. Because companies were allowed to carry losses on

paper forward year on year, some were able to operate in a virtually tax-free environment for many years.

Out of the Strategic Investment Programme's total of R10 billion in tax allowances, R813 million was allocated to pharmaceutical projects, specifically to promote generics for the treatment of HIV/AIDS and TB and leverage the opportunities for local companies provided by state tenders for ARVs. One of the beneficiaries was Aspen which received two tax allowances for different projects, one to the value of R110 million (for a projected capital of R170 million in 2003 that was escalated to R 360 m in 2008), the other to the value of R170 million (for a projected capital cost of R 170 million in 2005 that was escalated to R 370 million in 2008) (note: the source for these figures was not entirely clear). In 2010 this lowered Aspen's tax charge by R46 million.

Initially Aspen was principally associated with the provision of drugs for the treatment of chronic diseases, especially HIV and AIDS and TB. Today, however, it supplies branded and generic drugs, as well as nutritional and consumer products.

Aspen markets to roughly 100 countries worldwide (including Latin America, Asia-Pacific and Australia). It is Africa's largest pharmaceutical manufacturer, is able to meet stringent quality standards and has the capacity to manufacture some active pharmaceutical ingredients, both in South Africa and India. Aspen has four manufacturing sites in South Africa (Cape Town, East London, Johannesburg and Port Elizabeth) and one site in each of Kenya (Nairobi) and Tanzania (Dar es Salaam). Within South Africa Aspen is the top manufacturer of generics while, worldwide, it is one of the top 20 generics manufacturers.

Aspen is one of the top 40 companies listed on the Johannesburg Stock Exchange. In 2010 the revenue generated from Aspen's continuing operations was R10,1 billion, and its operating profit R2,6 billion, in both cases an increase of 20% over the previous year. Within South Africa, one in four script items dispensed in South Africa is for an Aspen product, the most for any company. Aspen accounts for almost 17% of sales in the private sector over the last year: its share of private sector sales appears to be growing rapidly (at 13%, compared to 3% total market growth). With respect to the public sector, Aspen has just been awarded around 40% of the government tender for anti-retrovirals. The value of the tender is estimated to be R3.6 billion over the next two years, starting at the beginning of 2011.

While Aspen's activities in Sub-Saharan Africa only contributed 9% of group revenue, Aspen is actively seeking to expand its activities in the continent to become the leading provider of affordable medicines. This expansion appears to be founded on two main strategies. First, in 2008 Aspen acquired a 60% interest in the ailing Tanzanian Shelys Group which has operations in Kenya and Tanzania. The deal has led to technology transfer, improved efficiency and quality, and the addition of Aspen brands to Shelys which is now planning to start ARV production (see Shelys Africa case study, Annex B). Shelys exports to Burundi, the DRC, Madagascar, Mozambique, Mauritius, Malawi, Uganda and Zambia, providing Aspen with a well-established East African distribution platform and a portfolio of well-recognised brands.

Second, in 2009 GlaxoSmithKline, which is the world's second largest seller of prescription drugs, acquired 16% of Aspen's shares, and a non-executive director on its Board. This was in exchange for:

- giving Aspen the rights to market, sell and distribute GlaxoSmithKline's pharmaceutical products in South Africa for a minimum of twenty years;
- collaborating with Aspen in the marketing and selling of pharmaceuticals to Sub-Saharan Africa under the brand 'The GSK Aspen Healthcare for Africa Collaboration' (most of the combined sales were formerly by GlaxoSmithKline);
- giving Aspen the rights to eight specialist branded products for worldwide distribution; and
- giving Aspen GlaxoSmithKline's manufacturing facility in Germany which produces some of the products that have been divested.

These transactions, which in 2009 had an estimated value of R3.5bn, addressed the complementary needs of the two partners. Aspen benefited by making use of GlaxoSmithKline's 300 sales representatives in Sub-Saharan Africa and using its brand credibility to market its own products. The arrangements also strengthened its manufacturing capabilities, portfolio of products and access to international markets. GlaxoSmithKline benefited from Aspen's strong delivery track record to grow its sales to emerging markets, one prong of a three-pronged strategy to deal with current business challenges faced by the global pharmaceutical industry. It also allowed it to streamline its operations, reduce manufacturing sites and divest itself of low priority brands.

For Aspen, growing its business in Sub-Saharan Africa is not without challenges, however. In recent years it has faced mounting pressure from other generic manufacturers, especially from Asia, who were encouraged to enter the East African market by the dropping of a 10% import duty on pharmaceutical products. Unable to lower its own prices in response because of contractual arrangements made under voluntary supply agreements, and despite marketing its own generic anti-retroviral products and acquiring voluntary licensing agreements, it still has had to diversify into other medicines to remain competitive. This is demonstrated by the GSK Aspen Healthcare for Africa Collaboration as well as a shift towards branded goods, over-the-counter medicines and distribution through supermarkets as has been done, for example, by Shelys. Increasing exports into other Eastern and Southern African countries has been another strategy adopted by Shelys, along with expanding its business into Australia, the United Kingdom and the United States.

Aureos Capital Ltd

Sources: Frontier Finance 2009; Reuters and Scott 2009; Aureos Capital 2011; International Finance Corporation Unknown

Aureos Capital Ltd was established in July 2001 as a joint venture between CDC Group PLC, the UK government's development finance institution and Norfund, the Norwegian Investment Fund for Developing Countries. It is a private equity fund management company with one of the longest track records of this sort in Africa. It specialises in providing capital to small- and medium-sized companies to allow expansion or buy-out and has over \$1 billion under management. Aureos has a global presence but it also has regional offices in Kenya, Tanzania, Zambia, South Africa and Mauritius.

In 2007 Aureos did an analysis of health care provision in East Africa, including identifying the reasons for health system failure. The study found that the health care sector is undercapitalized and suffers from inefficient management, including severe market fragmentation, inadequate distribution channels, high manufacturing costs, price distortions, ineffective supply chains, an absence of economies of scale, low productivity and an over-dependence on international health providers. Aureos seeks to provide financing opportunities for small and medium enterprises to address these problems. Aureos is credited with introducing Aspen Pharmacare to Shelys. Aureos has been appointed to deploy the Africa Health Fund with a focus on developing innovative partnerships with public and private organisations, particularly with respect to healthcare financing, medical manufacturing, healthcare training, telemedicine and pharmaceutical manufacturing.

Fortis Healthcare Ltd

Source: Bissoonauth and Martial 2009; Insurance News 2010

Fortis is an Indian private hospital group that was founded in 1996. It established its first hospital in 2001 and now owns a network of around 28 hospitals. It is headquartered in New Delhi. In 2009 Fortis acquired a private hospital in Mauritius that was formally known as Clinique Darné. Fortis is expanding the hospital as well as introducing super-specialties. In this, Fortis is aiming at the medical tourism market.

Harbinger Capital Partners

Sources: African Medical Investments 2010; Shazar 2010

African Medical Investment's strategy to develop into a leading operator of private hospitals in Africa is facilitated by a \$47 million or more investment in the company by the US-based hedge fund Harbinger Capital Partners. Harbinger now has a controlling stake in the company with around 54% of the shares. Harbinger has recently begun to invest in Africa as part of a new strategy to tap emerging markets. Its involvement in the private health sector possibly arises through its investment in a mining company which is run by the some of the same individuals running African Medical Investments.

The Health Insurance Fund

Sources: Health Insurance Fund 2010; Pharmaccess Foundation 2011

The Health Insurance Fund is an independent Dutch foundation that was initiated in 2005. It grew out of collaboration between a number of major companies (Heineken, Celtel, Unilever and Shell) that had become interested in health care development in Africa, initially through their involvement in workplace-based HIV/AIDS programmes. The Fund is registered in Amsterdam, The Netherlands. The initiative is supported by the Dutch Ministry of Development Cooperation with a subsidy of 100 million Euros for six years. Investments and technical support have also been received from a number of Dutch insurance companies and the Dutch multinationals that were involved in the initiative from the start. In 2008 the World Bank joined the Fund as an external funder. PharmAccess has been appointed as the main implementing partner of the Fund.

The Fund seeks to introduce *collective* private health insurance for low-income groups so that they may reap the benefits of prepaid financing and risk pooling. The intention is for external funders to subsidise premiums for low-income groups, although members will be expected to make a co-payment. The insurance schemes will cover basic health care services, including treatment of HIV/AIDS, tuberculosis and malaria. Quality will be enforced through performance-based payments to a network of providers who may also receive grants to upgrade their operations. It is intended that this initiative will generate an increasing demand for health insurance and have the potential to evolve into social health insurance.

This approach was based on PharmAccess's experience with a project it initiated in Namibia (the Okavango Project) between 2004 and 2009. Here, public funds subsidised insurance coverage for health care (including HIV/AIDS) in low-income communities and uninsured individuals in the formal sector for currently uninsured individuals. The project led to the introduction of new health insurance products for low-income Namibians and the creation of a Risk Equalisation Fund for HIV/AIDS, reportedly the first in Africa. On the back of this experience, in 2007 the Health Insurance Fund launched its first insurance scheme - the 'Community Health Plan' - in Nigeria, targeting market women in Lagos and a farming community in Kwara State. In 2008 the governor of Kwara State agreed to co-fund an insurance programme in the Afon district.

Other schemes are being prepared in other East and Southern African countries, starting in 2010 with Tanzania. Here, two target groups were selected to participate in the scheme: members of a micro-credit NGO called Pride and their families (around 12,000 people) and coffee farmers and their families organised in cooperatives. The local implementing partner in Tanzania for PharmAccess is the private health insurer Strategis.

The International Finance Corporation (IFC) and the IFC-World Bank Health in Africa Initiative

Sources: IFC News 2010; Insurance News 2010; International Finance Corporation 2010

The IFC-World Bank Health in Africa Initiative seeks to implement some of the recommendations arising from the IFC's report, *The Business of Health in Africa*. It is interested in fostering the following types of activities:

- health service delivery (e.g. clinics, hospitals, laboratories);
- risk pooling and financing vehicles (e.g. insurance companies, health management organisations);
- pharmaceutical and medical-related manufacturing companies;
- distribution and retail organisations (e.g. pharmaceutical chains, logistics companies);
- medical education providers; and
- ancillary businesses (e.g. waste management, IT providers).

As part of improving the operating environment for companies, the Initiative seeks to improve access to finance. To this end, the Initiative has established a private equity fund (The Africa Health Fund) and begun to partner with African commercial banks in Africa to increase the availability of debt finance. The Initiative intends to mobilise up to \$1 billion in advisory services and funds to create public-private partnerships that result in health services for underserved and low-income people. The initiative has engaged in a major campaign to convince governments, external funders and potential investors of the value of such an initiative.

With respect to the ESA region, and apart from its activities through the Africa Health Fund, the IFC has entered into a strategic partnership with Life Healthcare, the second-biggest private hospital chain in South Africa. IFC has invested \$93.1 million (essentially a 5% stake) to help the company invest in and transfer world-class hospital management expertise to other African countries and emerging markets in India and Turkey. IFC will jointly finance a subsidiary company to support Lifecare's expansion and will consequently also be investing in other countries in the region.

In Uganda, the IFC has made a \$3 million loan to Nakasero Hospital in Kampala. This loan will supposedly help expand health services in the country's lower-income and under-served areas, raise standards, and create jobs for medical professionals. The hospital is a private hospital established in 2009 and owned by Ugandan shareholders, most of whom are medical specialists practicing at the hospital. Laboratory services are outsourced to Lancet Laboratories Uganda Limited which is a joint venture with Lancet Laboratories of South Africa who own 80%. The role of the IFC in these deals is partly to provide a 'stamp of approval' to projects, encouraging private sector partners to provide co-funding.

Investment Fund for Health in Africa

Sources: Esper 2010; International Finance Corporation 2010; Investment Fund for Health in Africa 2010; Investment Fund for Health in Africa 2011

The Investment Fund for Health in Africa (not to be confused with the Health in Africa Fund or the Health Insurance Fund) is a Dutch private equity fund that was established in 2007 by the PharmAccess Foundation. The PharmAccess Foundation terms it 'a commercial fund for social private equity in the African health sector.' The Fund is based in the Netherlands but is also setting up an investment Fund in Mauritius to facilitate its investments. The Fund hopes to provide long-term capital – ranging from EUR 500,000 up to 15% of the Fund's total commitments - to 15-25 small to medium-sized private health care companies working in Africa and is managed by African Health Systems Management, a Dutch Company. Many of the team managing the Fund formerly worked for PharmAccess

The Fund has investments of EUR 50 million. The existing shareholders of the Fund are FMO, Goldman Sachs, Social Investor Foundation for Africa which includes ACHMEA, AEGON, Heineken, Shell, SNS-REAAL and Unilever), APG (a Dutch pension asset manager), the African Health System Management Company, the African Development Bank, Pfizer (the first pharmaceutical company to join and the IFC. It is proposed that the IFC invest up to €10 million,

not to exceed 19.9% of the total capitalisation of the Fund, and also advise the Fund on best practice. The Fund argues that investing in private health care companies will increase access to quality health care which in turn will lead to increased employment opportunities for healthcare professionals in Africa.

The Fund's first investment was in Hygiea, a Health Maintenance Organisation in Nigeria that implements the Health Insurance Fund. In the ESA region, the Fund's investments include Pyramid Pharma in Tanzania which is a pharmaceutical wholesale and distribution company, and Strategis Insurance Limited Tanzania. In 2010 it also bought a 20% stake in AAR East Africa, a medical insurance provider based in Nairobi but operating in several countries in the region (i.e. Kenya, Uganda, Tanzania, Rwanda). The Fund eventually hopes to own 60% of the company which is implementing a low-income health insurance project in the Rift Valley together with the PharmAccess Foundation.

Liberty Holdings

Source: Insurance News 2010

Liberty Holdings, a general insurance company, plans to sign up 1.5 million customers over the next three years as it expands health insurance products into Africa, specifically Botswana, Lesotho, and Zimbabwe.

Lifecare

Source: Insurance News 2010

The IFC has entered into a strategic partnership with Life Healthcare, the second-biggest private hospital chain in South Africa. IFC has invested \$93.1 million (essentially a 5% stake) to help the company invest in and transfer world-class hospital management expertise to other African countries and emerging markets in India and Turkey. IFC will jointly finance a subsidiary company to support Lifecare's expansion and will consequently also be investing in other countries in the region.

Medical aid societies in Zimbabwe

Extracted from: Shamu, Loewenson et al 2010: 2-3

'Medical aid societies (MAS) in Zimbabwe cover a tenth of the population, and about 80% of income to private health care providers in Zimbabwe comes from MAS. They contribute more than 20% of the country's total health expenditure ...

In Zimbabwe, medical aid schemes are voluntary. They deal directly with employers and consumers, avoiding broker costs, but also limiting employee discretion in the choice of society and inhibiting competition in the industry. Benefit packages are clearly specified, but are segmented, and lack cross-subsidies between different levels of cover, and different income groups of beneficiaries. MAS have encouraged growth of private hospital services in urban rather than rural areas, in order to lower administration costs and coverage is higher for the employed and wealthier groups, and lower in women, in rural areas and less wealthy people. Members of societies were found to be relatively loyal, remaining with their first medical aid society and only migrating on change of employment. While managed care systems claim to make it easier and less costly to access medicines, this was not found in this survey. Beneficiaries lacked information on benefit package options, and there was evidence of restrictive practice and benefits shortfall.

The economic liberalisation of the 1990s provided the impetus for greater investment in MAS and medical insurance through Greenfield investments, acquisitions and expansions. MAS responded to the economic decline and hyperinflationary environment of the 2000s by acquiring

related industries, to manage the costs of doctors, specialists and pharmacists. While contributions were used to finance this, other capital flows came from investors from South Africa, insurance companies, medical practitioners and banks. Despite societies aiming to use these acquisitions as a means to reduce co-payments, clients were found in this survey to be making a significant share of payments, including for drugs and consultation fees. Few beneficiary plans gave full reimbursement for services provided outside their managed care plans, and most clients reported needing to get approval from their MAS to use service providers outside those owned by the society. These changes were found to have led to a high degree of vertical integration between funders and different providers. This is of concern as it is associated with monopolies across all spheres of a sector, limiting patient choice, prescribing practices and use of laboratory services being driven by cost more than health need, and limits to people's ability to negotiate their interests with providers. This situation and concerns of the Competition and Tariff Commission in part contributed to the passing of the Medical Aid Societies Statutory Instrument 330 of 2000 regulating vertical integration. However regulatory oversight itself was found to have been constrained by shortages of personnel in a centralised system, ambiguities in the law, lack of information reporting from and monitoring of MAS, lack of consumer awareness and lack of advocacy of beneficiary interests by members. The societies have taken advantage of these shortfalls and ambiguities to consolidate their ownership across the sector and, for some, to default on obligations to provide annual financial reports to the Registrar or hold annual advisory council meetings. The Ministry of Health and Child Welfare has limited personnel capacity to regulate and monitor MAS, does not have an updated database on key features of MAS and does not retain the fees collected from MAS as it is not a statutory body. The Ministry of Finance also has obligations to monitor MAS as financial institutions. With their non-profit, non-tax status, their investments in non-core 'for profit' areas now raises new scrutiny on the use of their funds, with potential tax implications on profits earned.

The paper made proposals of measures to improve functioning and equity in the sector and to address the current exposure of beneficiaries, including:

- Strengthening the regulatory environment to address legal ambiguities on investment of the industry's 'surplus' funds, to ensure the multiple relevant laws from finance and health are known and applied by MAS/ insurance providers, and to fairly and firmly enforce the law.
- Ensuring timely scheme reporting as required by law and maintenance of a database with basic information on schemes.
- Ensuring registration of all schemes, avoiding increasing segmentation of the sector into small fragmented risk pools from individual schemes and encouraging (for example through enforcement of regulation on registration and liquidity requirements), mergers into larger and more viable risk pools.
- Introducing regulatory and scheme policy measures to require and implement cross-subsidies necessary for equity and ensuring benefits packages cover personal care and personal prevention services.
- Taking up the shortfalls in coverage of medicines on existing plans.
- Checking the degree of vertical integration in each scheme and unbundling any monopolies across the sector that are limiting patient choice (e.g. paying only for selected linked services).
- Improving the outreach of consumer information on schemes, benefits packages and consumer rights to members and organisations servicing members (e.g. the labour movement and employer organisations).'

The Medical Credit Fund

Sources: Pharmaccess Foundation 2011; Medical Credit Fund Unknown

The Medical Credit Fund was established in 2009 and is the first fund in the world to provide a combination of credit and technical advice to private primary care facilities and dispensaries in Africa. The rationale behind the Fund is that these providers typically find it difficult to access credit; this is a problem given that private provision needs to be upgraded and extended to meet

shortfalls in the provision of health care. The Fund provides loans which are administered by local banks at rates that are more affordable than ordinary loan facilities, in return for upgrading their medical practices. The Fund is managed by PharmAccess. Within the ESA region, the Fund began pilot programs in Tanzania and Kenya, involving approximately 20 providers in each country.

Medi-Clinic

Source: Insurance News 2010

Medi-Clinic, the third major private hospital group in South Africa, has operations in Namibia. Currently it appears to be seeking to expand into Switzerland and the Gulf States, rather than elsewhere in ESA.

Netcare

Source: Insurance News 2010

Netcare Holdings is the largest private hospital group in South Africa. It also has operations in Britain through its stake in General Healthcare Group.

Netcare Holdings entered into a public-private partnership with the Lesotho government and the Development Bank of Southern Africa in 2010. This partnership will replace the ageing Queen Elizabeth II Hospital in Maseru. The new hospital will be a national referral hospital and have around 425 beds: it will be the first new hospital that Lesotho has had in 50 years. The deal is worth \$100 million and was overseen by the IFC.

Netcare is reportedly planning to role out this model, in ESA to Swaziland, Zimbabwe, Zambia and the Democratic Republic of the Congo. The model mitigates risks for the private equity partner, Netcare. The government will pay the private sector back over eighteen years, as Netcare puts it, in return getting a modern, well-maintained and equipped hospital (although by that stage the physical infrastructure will have aged). Netcare acknowledges that attracting good personnel to work in the hospital will be a challenge but expects to pay better salaries to attract such staff. Although the return on investment will be lower than for an entirely private venture, one of the benefits to Netcare is boosting its social responsibility image, particularly as it has been accused, along with other private hospital groups, of helping to push health care costs up in South Africa. It is also possible that this public-private partnership provides a platform for the company to expand into other countries in the region as well as mitigate some of the risks normally faced by new private ventures.

The PharmAccess Foundation

Sources: Van der Gaag and Gustafsson-Wright 2007; Pharmaccess Foundation 2011

PharmAccess is a Dutch NGO that was established in 2004, initially to facilitate HAART access and develop HIV/AIDS programmes in Africa. It has always worked closely with the private sector, especially through designing and implementing workplace-based programmes. It has since become involved in the delivery of general care and has a particular interest in the provision and financing of this care through private health insurance mechanisms. PharmAccess now also facilitates investment in the African health sector. It co-founded the Health Insurance Fund in 2005 and, in 2007, the related Investment Fund for Health in Africa. It also manages the Health Insurance Fund and the Medical Credit Fund.

PharmAccess is active in many countries in the region. It has a two-pronged strategy. Firstly, it aims to stimulate the demand for health care by improving quality and subsidising access to private health insurance (through the Health Insurance Fund). Second, it aims to stimulate the supply of health care through providing private equity and debt financing for health care providers who hitherto have found it difficult to access these sources of financing (this is done through the

Investment Fund for Health in Africa and Medical Credit Fund in particular). External funding provided through the Health Insurance Fund is supposed to stimulate investment in the Investment Fund for Health in Africa as the risk to private investors is reduced through the stimulation of demand for insurance and health care. The role of PharmAccess is to provide technical support in developing programmes, setting up contracts with providers etc. The Brookings Institute is involved in researching components of the programmes developed by PharmAccess.

Shelys Africa Limited

Extracted from: Mhamba and Mbirigenda 2010: 12-13

'Shelys Pharmaceutical was established in Tanzania in 1984 when Tanzania embarked on its liberalisation policy and allowed private investors to invest in industrial production. Shelys Africa Limited is the holding company of a group of east African pharmaceutical companies ('the Shelys Group'), with major industrial operations in Tanzania (Shelys Pharmaceuticals) and Kenya (Beta Healthcare International) ... Shelys' manufacturing facility in Dar-es-Salaam is capable of manufacturing solids, liquids, capsules and penicillin, and its product portfolio includes: pain and fever management, coughs and cold, anti-malarials, antibiotics, antimicrobials and contraceptives. Beta Healthcare has its origins in the British Boots International and joined the Shelys Group in 2003. Its product portfolio comprises mostly over-the-counter drugs and a few branded pharmaceutical products. Beta Healthcare's domestic customer base is spread throughout Kenya, and export sales are generated in east and central Africa, including Tanzania, Uganda, Rwanda and Congo ...

Aspen Pharmacare Holdings Limited - a South African Pharmaceutical company listed on the Johannesburg Stock Exchange - acquired 60% of the share capital of Shelys Africa Limited in 2008 ... Capital flow from Aspen Holdings to Shelys Pharmaceutical industry has been used to upgrade the company's manufacturing capability to produce solids, liquids, capsules and penicillin ...

Although Shelys/Aspen is the leading supplier of locally produced essential medicines in Tanzania, it does **not** have an explicit policy or strategy focused on meeting the needs of the poor by providing access to essential medicines through local production and/or affordable pricing. A decreasing share of Shelys Pharmaceutical products are now marketed in Tanzania (from 65% in 2008 to 59% in 2009), due to increased export to new markets (e.g. Rwanda and Democratic Republic of Congo) and a larger share of export to Zambia ...'

Strategis Insurance (Tanzania) Limited

Extracted from: International Finance Corporation 2007: 71

Strategis Insurance (Tanzania) Limited was the first private specialist health insurer to be registered in Tanzania in March 2003 (Health Insurance Fund 2010).

'Tanzania's leading private insurer, Strategis has experienced rapid growth from corporate subscribers, and has set aggressive growth targets for underwriting large insurance funds, more local companies, and individuals.

- Strategis offered the first private health insurance in Tanzania. It designs, underwrites, and sells medical insurance to:
 - Companies
 - Affinity groups
 - Families and individuals
 - Travel cover (in/out)
- Three percent profit before tax, almost exclusively from underwriting given limited investment income opportunities.
 - Currently > 90% corporate, plan to increase retail to 30%.

- Network of > 100 contracted private providers throughout the country.
- Quality standards part of provider contract, but hard to enforce if no alternative provider is available.
- Expatriate management provided through AMSCO project (funded by UN and IFC).
- 30,000 of Tanzania's 60,000–70,000 insured lives.
- ... Strategis has experienced rapid growth from corporate subscribers...
- Four year old company with 2005–2006 subscriber growth of ~50%.
- Past growth driven by corporate accounts (first multinational corporations, then local companies).
- ...and has set aggressive growth targets for underwriting large insurance funds, medium-sized enterprises and individuals.
- Growth targets of doubling underwriting in 2007 and 50% growth in 2008.
- Strategis has tendered for new Dutch Health Insurance Fund contract to insure large, generally non-wealthy population.
- Corporate insurance continues to offer near term growth with good margins.
- Retail growth opportunity in medium-term, given growth in employed families seeking quality care.
 - Currently <10% retail, with 30% target
 - First local company with individual risk assessment capability for retail underwriting. Able to partner with affinity groups and banks for retail volume.
- Key growth challenges include:
 - Competition from new entrants for both subscribers and personnel.
 - Uncertain regulatory environment: New legislation expected on HMOs may have consequences for registered insurers.
 - Uncertain impact of National Health Insurance Fund's aspiration of growing coverage to 45% of Tanzanian lives by 2015.'

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; MHEN Malawi; HEPS Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; and SEAPACOH

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